MILLIMAN REPORT

State of Florida Department of Health

Children's Medical Services Managed Care Plan Invitation to Negotiate ITN Plan Financial Commitment Template Narrative

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EXHIBITS

I. FINANCIAL COMMITMENT TEMPLATE OVERVIEW

The purpose of the Children's Medical Services Managed Care Plan (CMS Plan) Financial Commitment Template ("template") is to assist the State of Florida Department of Health (Department) and its consulting actuaries in several areas of the invitation to negotiate (ITN) process for CMS Plan (Title XIX and Title XXI). Some of these areas include:

- Identify areas where respondents can provide the most value in the CMS Plan rate-setting process relative to the historical experience in the current program
- Receive additional supporting information underlying respondents' financial commitments
- Compare future financial commitments across respondents for reasonableness
- For respondents currently operating CMS Plan, compare commitments to prior financial results to contextualize future financial commitments

The information collected in this template will help inform attainable and achievable benchmarks to be implemented and measured in the rate development process for the upcoming contract period. These benchmarks are expected to be committed to by respondents for specified periods of time. This solicitation, including all its addenda, the Department's written response to written inquiries, and the successful respondent's response, including information provided through negotiations, shall be incorporated by reference in the final Contract document.

The purpose of this document is to provide respondents with guidance and instructions for completing the template required in Exhibit A-6-a of this solicitation.

TEMPLATE OVERVIEW

The template focuses on key components of the capitation rate development process that the Department and its actuaries have identified for potential improvements from the current program. The Department intends to use the respondents' template submissions to develop annual achievable commitments for the areas listed below for each year of the contract. These commitments will then be included in the development of actuarially sound capitation rates that do not vary other than for existing mechanisms, such as risk adjustment. Further details regarding this approach by assumption can be found in subsequent sections of this document.

Respondents will include the following information within their templates:

- CMS Plan administrative expenses
- CMS Plan managed care initiatives
- CMS Plan nursing facility transitions
- CMS Plan margin
- CMS Plan expanded benefits

Additional instructions on how to populate each spreadsheet of the template are provided in Section II.

Respondents must also provide an Actuarial Memorandum and certification describing how the respondent's financial template responses were developed. Separate instructions and questions to respond to within the Actuarial Memorandum and certification can be found in Exhibit A-6-b. These responses will help the Department and their actuaries to better understand the methodology used by each respondent to complete the template, ensure consistency of responses across respondents, and ensure the assumptions are reasonable.

Respondents should review this entire document and the Excel template prior to populating the templates.

CMS PLAN DATA BOOK

The Department posted a data book providing relevant background information that respondents may find useful in the development of their response to this solicitation. The data book consists of a comprehensive set of utilization and cost data consistent with actuarial rate-setting practices and standards. It includes a description of the data sources and all adjustments applied to the data to produce the data book. The data book consists of the following information:

- CMS Plan Data Book
  - Cover Letter for CMS Plan Data Book (dated July 10, 2024)
  - CMS Plan Title XIX Data Book Narrative and Appendices (dated July 10, 2024)
  - CMS Plan Title XXI Data Book Narrative and Appendices (dated May 9, 2024)
- Data book public meeting materials for Title XIX (dated January 5, 2023)
- Data book question and answer document (dated February 28, 2023)

Respondents may consider the information in the CMS Plan data book when developing and completing their templates, but they are not obligated to rely on it. Respondents are not restricted to the data and summaries provided by the Department for use in preparing the template. Respondents are solely responsible for research and preparation of the templates.

CMS PLAN PROGRAM STRUCTURE

The Department intends to alter various aspects of CMS Plan as part of this solicitation. This section outlines the intended structure for the modified version of CMS Plan.

Rate Groups

The Department and its consulting actuaries set actuarially sound program capitation rates separately for the CMS Plan Title XIX rate groups summarized in Table 1. The Department of Health currently funds medical services through capitation rates developed and paid to the CMS capitated plan on a PMPM basis for CMS Plan Title XXI. Refer to the CMS Plan data book for a detailed description of each rate group.

Table 1
State of Florida Department of Health
CMS Plan Program
Rate Groups

CMS Plan Title XIX – Private Duty Nursing
CMS Plan Title XIX – Non-Private Duty Nursing
CMS Plan Title XXI

Rate Regions

The Department will restructure Title XIX CMS Plan into nine rate regions, consolidating the current structure of the Title XIX CMS Plan which includes 11 rate regions.

As part of the new program, current Title XIX regions 1 and 2 will become region A; current regions 3 and 4 will become region B; and regions 5 through 11 will become regions C through I, respectively. Table 2 reflects the rate regions and corresponding counties as part of the restructured CMS Plan program.

Title XXI CMS Plan will continue to include three rate regions: North, Central, and South.

Table 2 State of Florida Department of Health CMS Plan Program Rate Regions		
Title XIX Rate Region	**Title XXI Rate Region**	**Counties**
A	North	Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington
B	North	Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau, Putnam, Sumter, St. Johns, Suwannee, Union, and Volusia
C	Central	Pasco and Pinellas
D	Central	Hardee, Highlands, Hillsborough, Manatee, and Polk
E	Central	Brevard, Orange, Osceola, and Seminole
F	Central	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
G	South	Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie
H	South	Broward
I	South	Miami-Dade and Monroe

II. GENERAL INSTRUCTIONS

This section provides information around the template file, including general instructions for the population of the file. Please note, technical instructions for the population of the template can be found in the "Instructions and General Inputs" spreadsheet of the Excel template.

TEMPLATE OVERVIEW AND STRUCTURE

This section provides an overview of the structure of the template, including each spreadsheet of the template. Further details regarding these spreadsheets are outlined in the next section of this document. The following sheets are included in the template:

- **Instructions and General Inputs**:
  - Respondents will populate several general inputs related to their proposed plan offering. Each of these inputs will determine which sections should or should not be populated on subsequent spreadsheets of the template. Additionally, this spreadsheet outlines the overall instructions for the completion of the template.
- **CMS Plan Membership**:
  - Respondents currently operating in the program should provide historical membership data by calendar year (CY) from CY 2019 through CY 2023 by region and rate group for CMS Plan. This membership is used to aggregate historical results in subsequent spreadsheets within the template.
  - Respondents not currently operating in the program will leave this spreadsheet blank.
- **CMS Administrative Expenses**:
  - Respondents currently operating in the program should provide historical administrative cost data by calendar year from CY 2019 through CY 2023 by region and rate group split by core functions, case management, administrative costs associated with sub-capitation payments, and value-added (quality improvement services) functions for CMS Plan. Note, these amounts (less administrative costs associated with sub-capitation payments) should align with amounts reported in the ASR financial data.
  - All respondents should provide projected PMPM administrative costs by rate group split by core functions, case management, and value-added (quality improvement services) functions for each year of the upcoming contract.
  - At the top of the sheet, all respondents should provide a response to the question of differences between anticipated administrative cost efficiencies for Contract Year 1 (relative to your plan's projected experience for October 2023 - September 2024) and efficiencies assumed between each contract year after Contract Year 1.
- **CMS Additional Program Costs:**
  - Respondents should populate this worksheet to outline the incremental medical or administrative costs PMPM expected as a result of the ITN.
- **CMS Plan NF Transitions:**
  - Respondents should provide a qualitative response to assist the Department with understanding initiatives that the respondent proposes to take to transition children with complex needs (often requiring PDN services) included in the US v. FL case from facility-based care settings to home and community-based settings. If there any potential options the respondent can recommend that would allow for the capitation rates to assist in supporting these initiatives, please also provide a qualitative response of the proposed changes.

- **CMS Managed Care Initiatives**:
  - Respondents currently operating in CMS Plan should provide historical CMS Plan managed care initiatives.
  - All respondents should provide projected CMS Plan managed care initiatives for each year of the upcoming contract.
- **CMS Managed Care Savings:**
  - Respondents should provide projected aggregate annual savings percentages (relative to the prior rate year) due to CMS Plan managed care initiatives by region (if possible) and on a statewide basis. Respondents currently operating in the CMS Plan program should also provide historical savings.
- **CMS Plan Margin**:
  - All respondents should provide proposed margin and expanded benefit commitments as a proportion of the capitation rates for CMS Plan for the duration of the upcoming contract.
- **Expanded Benefits**:
  - Respondents currently operating in CMS Plan should provide their historical expanded benefit experience by expanded benefit type separately for CMS Plan and pathways to prosperity.
  - All respondents should provide Year 1 projected expanded benefit experience by expanded benefit separately for CMS Plan and pathways to prosperity.
- **Notes**:
  - A blank "Notes" spreadsheet is provided for respondents to use as needed to convey additional information to the Department not covered by the template.

Respondents must enter a value into each blue shaded cell on all required spreadsheets. Subsequent portions of this document include additional details for each section of the template.

INSTRUCTIONS AND GENERAL INPUTS

Respondents will populate several inputs which dictate how the remainder of the template should be populated. This section outlines the various selections for respondents on the *Instructions and General Inputs* sheet. To enhance the comparability across respondents, membership used for future contract years within the template are standardized to allow for consistency across respondents, and it is not a reflection of actual membership respondents will enroll if awarded a CMS Plan contract. The following outlines the key inputs used to determine the necessary information and future membership reflected in the *Instructions and General Inputs* sheet.

Current CMS Plan

Respondents that currently operate in CMS Plan are required to populate historical information throughout the template. Respondents not currently operating in the program will not need to provide this information, and the historical information will be grayed out in the template.

III. ADJUSTMENT SPECIFIC INSTRUCTIONS

This section provides detailed information around the various components of the template the Department has selected in order to review each respondent's ability to provide the best value to CMS Plan. The following sections will provide additional information as to how each respondent is expected to populate these components within the template and provides additional insight as to how the template will be used to develop plan commitments. Note, Section IV outlines additional supporting documentation required for each of the adjustments included in this section. This section focuses solely on the population of the template, but respondents are required to provide additional support for the template inputs consistent with the items outlined in Section IV.

CMS PLAN MEMBERSHIP

The purpose of the "CMS Plan Membership" spreadsheet is to allow respondents to provide historical member months (if applicable) and standardize a base of member months for respondents throughout the template. Respondents that currently operate in CMS Plan should include historical membership information for the CY 2019, CY 2020, CY 2021, CY 2022, and CY 2023 columns of this spreadsheet by rate group, and region based on the member months reported in the year-end Achieved Savings Rebate (ASR) financial reports. Title XIX historical regions 1 through 11 should be converted to regions A through I for the future contract, using the mapping outlined in Table 2. Each respondent should input actual member months counts for each historical CY. Member months are calculated by taking the number of individuals enrolled and multiplying that sum by the number of months (may be fractional months due to express enrollment) that individual was covered in the given CY.

Respondents should not input the future rate year (RY) member months on this spreadsheet. These member months are automatically populated. The respondent should review the future RY member months and develop the remaining inputs in this template (i.e., administrative expenses) consistent with expected costs.

CMS ADMINISTRATIVE EXPENSES

The purpose of the administrative expense spreadsheet is to understand historical expenses associated with administering services within CMS Plan, as well as future administrative expenses that will be required during the upcoming contract.

At the top of the sheet, all respondents should provide a response to the question of differences between anticipated administrative cost efficiencies for Contract Year 1 (relative to your plan's projected experience for October 2023 through September 2024) and efficiencies assumed between each contract year after Contract Year 1.

The remainder of the spreadsheet is split into four primary administrative functions:

- **Case Management:** Administrative costs in this section should include expenses incurred for the direct service component of case management services, consistent with the definition outlined in the ASR financial report. The ASR financial report can be found listed on the Agency website (https://ahca.myflorida.com/Medicaid/statewide_mc/report_guides/asr_fin.shtml). Expenses for the support of case management services shall be reported in Core Functions.

- **Health Care Quality Improvement Functions:** Administrative costs in this section should be equivalent to the amounts reported in Section 4 of the "MLR Exhibit" spreadsheet of the ASR financial report. Specifically, this section includes improved health care quality expenses incurred based on the following federal guidance:

  - 45 CFR Part 158.150: This includes improving health outcomes, activities to prevent hospital readmissions, improving patient safety and reducing medical errors, and wellness and health promotion activities.

  - 45 CFR, 151.151: This includes health information technology (HIT) expenses related to health improvement.

- **Administrative Costs Included in Sub-capitation Arrangements (Historical Reporting Only):** This section includes any administrative costs included with sup-capitation payments made historically. In the ASR reporting, plans currently participating in CMS Plan do not separate these amounts from the medical expenses included in the payments.

  Note, this is for historical reporting purposes only: For future contract years, plans should allocate anticipated sub-capitated payments associated with administrative costs across the other three primary administrative functions.

- **Core Functions:** This section includes any administrative costs that are not reported in the other sections.

Respondents should input per member per month (PMPM) administrative costs in the areas shaded in blue for columns applicable to the respondent.

All respondents should enter in values in the blue shaded areas of the contract year 1 (February 2025 through September 2025) column and the assumed efficiencies columns relative to Contract Year 1 for future contract years. Note, the assumed efficiencies should be input as the percentage change from the prior year. For example, if the respondent assumes they can be 2% more efficient between Contract Year 1 and October 2025 through September 2026 (RY 25/26), they should enter 2% as the "Assumed Efficiencies (Relative to Contract Year 1)."

- **Plans currently participating in CMS Plan** should also provide actual historical administrative costs in the blue shaded areas for CY 2019, CY 2020, CY 2021, CY 2022, and CY 2023 for rate groups applicable to the plan. The historical administrative costs should reconcile to the year-end ASR financial reports provided to the Department by the plan. For plans that merged with or acquired other plans, respondents should report the historical results for the new plan name only, not any membership associated with the acquired plan prior to the acquisition. Any discrepancies between the reported costs and the year-end ASR financial reports should be detailed and explained with the supporting documentation.

Respondents should assume the following when completing this spreadsheet. The Department's actuaries will make adjustments to these assumptions when considering administrative costs in the rate development for future contract years.

- **Trend:** Respondents should assume 0% annual trend for each of the contract years after Contract Year 1. Actuaries will consider trend separately from respondents' efficiencies in future rate development.

- **Enrollment levels:** Respondent should base administrative costs on the member months provided in the template across all contract years. Respondents should not assume any changes in either overall enrollment, rate groups, or programs in future contract years. The total administrative costs across all rate groups are automatically aggregated in the template based on membership.

- **Programmatic / Contractual Changes:** Respondents should not assume any future programmatic or contractual changes beyond those already in place in CMS Plan or included in the Scope of Services in this ITN.

Below are additional instructions to consider as respondents complete this spreadsheet:

- **Efficiencies:** For each contract year, incremental efficiencies relative to the prior contract year should be entered into the spreadsheet.

- **Start-up / Transition Costs:** Any administrative costs related to being new entrant to CMS Plan should be excluded from any administrative costs entered in this spreadsheet.

- **Allocation of Administrative Costs:** Respondents should allocate administrative costs across rate groups using any information available to the plan to create reasonable allocations.

- **Pharmacy Benefit Manager (PBM) Fees:** Payments made by plans to the PBM vendor for administration of their pharmacy benefit should be included in the administrative costs bid by respondents.

- **New Value-Based Purchasing (VBP) Contractual Requirements Required as Part of the ITN:** Respondents should exclude any additional administrative costs related to VBP contractual requirements in the ITN that respondents have not already implemented by CY 2023.

CMS ADDITIONAL PROGRAM COSTS

As part of the ITN, programmatic and contractual changes or other commitments may result in additional medical or administrative costs for the managed care plan relative to the existing program. Respondents should populate this worksheet to outline the incremental medical or administrative costs PMPM expected due to these changes and commitments. Note, respondents not currently participating in the CMS Plan program are not expected to provide incremental medical or administrative costs PMPM due to programmatic or contractual changes in the Scope of Services and may only provide additional costs associated with proposed commitments beyond those listed in the Scope of Services given the lack of experience in the current program. In the additional program costs section of the Actuarial Memorandum, respondents should provide the methodology and supporting calculations or documentation used to complete this worksheet.

Respondents must populate the following:

- **Submission Requirement Component (SRC):** Respondent should outline the SRC for which the contractual change or additional commitment is being made ('Other' if not applicable to a specific SRC). Additional information regarding the SRC will pre-populate.

- **Description:** Respondents should outline a description of the relevant contractual change or additional commitment.

- **Medical or Administrative Expense:** Respondents should select whether the additional costs are attributed to medical costs or administrative costs.

- **Additional Projected Contract Year 1 Expense:** Respondents should provide the additional costs PMPM for the contractual change or additional commitment. These member months are provided above each product on this worksheet for reference.

- **Notes:** This section is optional and allows respondents to provide any additional information they deem relevant.

CMS PLAN NF TRANSITIONS

Respondents should provide a qualitative response to help the Department understand initiatives that the respondent will take to help transition children with complex needs (often requiring PDN services) from facility-based care settings to home and community-based settings. If changes in the capitation rate structure is needed to support these initiatives please also provide a qualitative response of the proposed changes.

CMS MANAGED CARE INITIATIVES

The Department's rate methodology includes consideration of additional managed care savings that respondents can achieve above any historical managed care savings achieved. The purpose of this spreadsheet is to understand historical managed care initiatives and their impact on the costs of CMS Plan and understand the impact of managed care initiatives that will be implemented during the upcoming contract.

Respondents should input savings as a result of managed care initiatives in the areas shaded in blue for columns applicable to the respondent. All savings should be input as a percentage of medical savings relative to the prior period for the costs associated with the rate group, category or categories of service, and optionally region.

- **All respondents** should enter in values in the blue shaded areas for "Projected Future Savings."
  - For Contract Year 1, input the projected savings that the respondent can achieve relative to the current CMS Plan program experience for CY 2021 included in the data book.
  - Starting with Contract Year 2, the assumed savings should be input as the incremental percentage change from the prior year. For example, if the respondent assumes they can be 2% more efficient due to a given managed care initiative between Contract Year 1 and RY 25/26, they should enter 2% in the column "Contract Year 2 (RY 25/26) Relative to Contract Year 1."
- **Plans currently participating in CMS Plan** should also provide historical savings by rate year relative to the prior period in the blue shaded areas. Note, negative amounts in some periods may be appropriate if there are investments that result in offsetting savings in other periods.

Below are additional instructions for respondents as they complete the managed care savings adjustments section of the Template:

- Respondents should exclude anticipated savings or costs due to new VBPs based on this solicitation. However, anticipated savings due to existing VBPs or new VBPs not associated with this solicitation should be included.
- Managed care savings figures must exclude the impact of base data adjustments, trend, provider contracting adjustments, and other adjustments explicitly included on other spreadsheets in this template, so that the impact of each factor is only considered once.
  - Include support for the data, assumptions, and methodology underlying the net savings projection.

MARGIN / EXPANDED BENEFITS

Since the inception of CMS Plan, the load for projected margin for capitation rates have been 2% of the capitation rates. As part of this solicitation, the Department is considering modifications to the percentage of margin included in capitation rates for CMS Plan. The "Margin" spreadsheet of the template allows for the respondent to input proposed margin levels for the program. The Department has defined a range of acceptable margin level for this solicitation**.** Respondents must input a margin level between 1.5% and 2.0% of the capitation rate. Respondents should not vary this margin level across regions or rate groups within CMS Plan.

Any expanded benefits covered by respondents will not be included as part of the CMS Plan capitation rates. Therefore, expanded benefits are expected to be covered by CMS Plan without reimbursement, resulting in an offset to any margin earned by respondents. To understand how these expanded benefits may affect overall plan results, respondents should enter the proposed amount of the margin that a plan is willing to commit to expanded benefits. This amount should not exceed the proposed margin level for the respective program. Additionally, the expanded benefit commitment should align with all other expanded benefit information included in the template and the overall solicitation response from the respondent. The margin net of expanded benefits will calculate automatically within the template based on the inputs for margin and expanded benefits commitments.

Based on a review of templates, the Department will determine a program-wide margin level for capitation rates for each of the future years of CMS Plan. Note, these may vary across rate years.

INDIVIDUAL EXPANDED BENEFITS

The current Title XIX CMS Plan offers various expanded benefits to their members. These benefits are services not covered by standard benefits under the Florida Medicaid State Plan services, but they are instead funded by the plan outside of the capitation rates (i.e., at the plan's expense) as part of their contract. Respondents should populate the following spreadsheets with their proposed expanded benefits for February 2025 – September 2025 (Contract Year 1):

- "CMS Plan Expanded Benefits" – CMS Plan expanded benefits for members.
- "P2P Expanded Benefits" – CMS Plan expanded benefits associated with pathways to prosperity (P2P).

The Department has a specific focus on several P2P expanded benefits as laid out in SRC 7 and 8. These specific expanded benefits are pre-populated in the respective spreadsheets of the template. Respondents are expected to complete information for each of these expanded benefits if they are offering them.

Respondents also have the ability to offer additional expanded benefits for CMS Plan. Any additional expanded benefits offered by respondents should be added in the blue shaded area of the "Benefit Description" section, and the appropriate information should then be completed on that row. Below are additional instructions on completing this section:

- **All respondents** should enter in values in the blue shaded areas for the "Benefit Description," "Covered" and "Contract Year 1, (Expected)" sections.
  - Respondents should indicate whether they intend to cover the list of expanded benefits pre-populated in the "Benefit Description" column by choosing "Yes" or "No" in the "Covered?" column.
  - Respondents should populate the list of additional expanded benefits (if necessary) beyond those pre-populated based on SRC 3 in the "Benefit Description" column and enter "Yes" in the "Covered?" column.
  - All respondents should provide projected utilization and PMPM cost information by expanded benefit. Respondents should populate the Contract Year 1, (Expected) utilization per 1,000 and cost PMPM amounts in column I and J, respectively. Respondents are expected to populate these columns for any expanded benefit with a "Yes" in the "Covered?" column.
- **Plans currently participating in CMS Plan** should also enter in values in the "Calendar Year 2023 (Actual)" section.
  - For each expanded benefit listed, respondents should indicate whether they intend to cover the list of expanded benefits pre-populated in the "Benefit Description" column by choosing "Yes" or "No" in the "Covered?" column.
    - Expanded benefits offered during CY 2023 should each be listed, even if the respondent does not intend to cover that expanded benefit under the new contract.
    - If the respondent selects "Yes," respondents should also enter in the information in the "Contract Year 1, (Expected)" section.
    - If the respondent selects "No," the "Contract Year 1, (Expected)" section should be left blank.
  - Respondents should provide CY 2023 utilization per 1,000 and cost PMPM amounts by expanded benefit in the "Calendar Year 2023 (Actual)" section (regardless of the selection in the "Covered?" section) unless the benefit will be newly covered in Contract Year 1.
    - The costs PMPM by benefit and in aggregate should align with the amounts reported in the CMS Plan ASR financial reports.

To assist respondents in understanding the historical costs associated with various expanded benefits, the data book includes an exhibit to reflect historical CMS Plan averages:

- "Exhibit 4-D" worksheet of "Appendix 2 - Exhibit 4 – CMS Plan Title XIX Data Book Applicable Adjustments.xlsx."

V. CAVEATS AND LIMITATIONS

We prepared this report and the respective exhibits for the specific purpose of assisting the Department in developing a template for potential respondents responding to the CMS Plan Invitation to Negotiate (ITN). This report may not be appropriate, and should not be used, for other purposes.

This report and the respective exhibits are intended solely for the benefit of the Department. We understand that this material will be shared publicly by the Department, and we recognize that materials delivered to the Department may be public records subject to disclosure to third parties; however, Milliman does not intend to benefit, and assumes no duty or liability to, parties other than the Department who receive this work. This material should only be distributed and reviewed in its entirety.

In preparing this material, we relied on several sources of data and information from the CMS plan, the Florida Agency for Health Care Administration (Agency), the Department, and other sources. Those data sources and information include Department eligibility data and other supporting information from the Department and the plan. We relied on the Department for the accuracy of the eligibility data and other supporting information. **We did not audit any of the data sources or other information**, but we did assess the data and information for reasonableness. If the data or other information used is inadequate or incomplete, the results will be likewise inadequate or incomplete.

Milliman has developed the template. The intent of the model is to aid in the review of financial commitments proposed by respondents. We have reviewed this model, including its inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs). The models, including all input, calculations, and output, may not be appropriate for any other purpose.

Future CMS Plan experience will differ from the contents of the template due to health care trend, managed care efficiency, provider reimbursement changes, enrollment demographic changes, the impact of the COVID-19 pandemic, and many other factors. The template does not reflect projections of future costs.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Andrew Gaffner, Jill Bruckert, and Kyle McClone are actuaries at Milliman, are members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial communication contained herein. To the best of our knowledge and belief, this communication is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

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